Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SOUTHWEST GENERAL HOSPITAL 1415 LOUISIANA ST STE 2225 HOUSTON TX 77002-7392	MFDR Tracking #:	M4-07-4941-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: Association Casualty Insurance Co. Box #: 53	Date of Injury:	
	Employer Name	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Apparently the Payor improperly applied the ASC Fee Guideline or utilized some other no-applicable fee schedule to significantly underpay this claim… It is neither 'fair' nor 'reasonable' for the payor to apply a non-applicable Medicare fee schedule to this claim. It would be significantly more 'fair and reasonable' for the Hospital to be reimbursed based on the average commercial (non-governmental) managed care contract reimbursement rate… An audit of all of the Hospital's non-governmental managed care contract reimbursement rates has confirmed the average reimbursement for this same outpatient surgical procedure is 65% of the Hospital's billed charges… the Hospital should be paid nothing less than 65% for this claim."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $4,460.90
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The attached charges have been reimbursed to the medical provider for services rendered in a fair, reasonable and consistent methodology, pursuant to Section 413.011"… "The methodology employed is consistently applied to all medical providers, and it is designed to ensure the quality of medical care and to achieve effective medical cost control"…

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/26/2006	45, B15, 510, W10, W4	Outpatient Surgery	$4,460.90	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 45 – "Contract/Legislated Fee Arrangement Exceeded"
   - B15 – "Procedure/Service is not paid separately"

- 510 – "Payment Determined"
- W10 – "Payment based on fair & reasonable methodology"
- W4 – "No additional payment allowed after review"

2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

4. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a copy of all medical bill(s)"… "as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter"… This request for medical fee dispute resolution was received by the Division on April 5, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division under 28 TAC §133.307(c)(2)(A).

5. Division Rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable..." The requestor's position statement asserts that "It is neither 'fair' nor 'reasonable' for the payor to apply a non-applicable Medicare fee schedule to this claim. It would be significantly more 'fair and reasonable' for the Hospital to be reimbursed based on the average commercial (non-governmental) managed care contract reimbursement rate." However, the requestor did not provide convincing evidence to support that a methodology based on the average commercial (non-governmental) managed care contract reimbursement rate would yield a fair and reasonable result. The requestor does not explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support that payment of the amount sought would be a fair and reasonable reimbursement. The requestor did provide a list of "Rate Comparisons of Top Payors" showing the average percentage of reimbursement received from its top commercial carriers, however, the requestor did not submit EOBs, reports, service dates, or data to support the list or demonstrate how the summary was compiled. The submitted documentation is not sufficient to meet the requirements of Division rule at 28 TAC §133.307(c)(2)(G).

6. Additionally, the Division has determined that a reimbursement methodology based upon payment of a percentage of the hospital's billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that

> "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment in the amount of the provider's billed charges would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement in the amount sought by the requestor cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence.

After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	4/30/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.